STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT NEW CASTLE	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from June 27, 2012 through June 28, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the survey was 117. The survey sample included 5 resident's.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	F225 August 15, 2012 1. Resident R2 no longer resides in the center. 2. Incidents/accidents and complaints are reviewed daily during morning managers meeting to determine that investigations were initiated, completed, and reported in accordance to State and Federal laws. 3. The leadership team will be informed by the administrator on or before July 31, 2012 on their responsibility and the process of reporting and investigating alleged abuse, neglect, mistreatment, and/or injuries of unknown sources. Random incident audits of 5% will be conducted by the DON/NHA over the next 30 days to review documentation to determine that proper and timely procedures are followed. 4. The NHA will report to the QA committee monthly. The QA committee will analyze the data to determine the need for further recommendations and follow-up to enhance and improve outcomes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kathleen M Pucci, Administrator July 17, 2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and other documentation it was determined that the facility failed to ensure one resident (R2) out of five sampled residents that had the potential for abuse/neglect of care was immediately reported to the State Agency, thoroughly investigated and the results of the investigations were reported within 5 working days to the DLTCRP) Division of Long Term Care Residents Protection). Findings include: Review of R2's clinical record revealed she was admitted to the facility on 1/23/12 with diagnoses of dementia, hypertension, depression, osteoarthritis, hypothyroidism, diabetes mellitus, hyperlipidemia, neuropathy, chronic obstructive pulmonary disease, compression fracture and history of falls. Review of the facility Accident/Incident Report dated 2/29/12 revealed that R2 had an unwitnessed fall on 2/29/12 in her bathroom. Two of R2's family members alleged that the resident was left alone on the bathroom floor, without staff	F 225		

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F 225	Continued From page 2 supervision for a period of time after the fall. The resident was sent to the hospital via 911, and diagnosed with a contusion to the back of her head and returned to the facility on 3/1/12 at approximately 2:30 AM. Review of facility records revealed that on 3/1/12, R2's family member filed a Facility Resident Concern Report. The nature of the concern was that R2 was left alone on the bathroom floor and without staff supervision while a CNA (Certified Nursing Assistant) went to get a nurse. Additionally, the family member was concerned that there were no staff present when the paramedics arrived to take R2 to the hospital. The Resident Concern Report was signed by E1 (administrator) on 3/1/12. Although the facility investigated the fall, the facility failed to report the allegation of neglect to the Division of Long Term Care Residents Protection. These findings were discussed with E1 and E2 (Director of Nursing) on 6/21/2012.	F 225	F279 August 15, 2012 1. Resident R3's care plan was updated. 2. Current residents who are care planned for hygiene/incontinent care, will be reviewed by the ICP team at their next scheduled care plan meeting to ensure care plans contain problem identification, measurable goals, realistic and individualized approaches. 3. Inservices will be held for nursing staff on or before July 31, 2012 on the development of a comprehensive care plan, to include interventions appropriate that meets the needs of the resident. 4. This will be the responsibility of the nursing team, DON/ADON, and nurse manager. The DON/designee will report to the QA committee monthly. The QA committee will analyze the data for further recommendations.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 3 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined for one (R3) out of 5 sampled residents the facility failed to develop a comprehensive care plan which included interventions to meet the resident's medical and nursing needs that are identified in the comprehensive assessment. Findings include: Review of R3's clinical record revealed she had diagnosis that included Hypertension, Depression, Hypothyroidism, Coronary Artery Disease and was legally blind. Review of the annual Minimum Data Set (MDS) assessment, dated 11/8/11, revealed that the Care Area Assessment (CAA) triggered for urinary incontinence and was checked off to proceed with care planning. Although the facility developed a care plan on 11/09/11 for the problem "Alteration in urinary continence plan", and included measurable objectives and timetables, they failed to describe interventions or approaches that were to be used in order to obtain the care plan's objectives. The care plan was reviewed on 1/28/12 and 4/22/12. However there again were no	F 279		

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F 279	Continued From page 4 interventions identified. On 5/11/12 one intervention was added for the completion of a urinalysis. An interview with E10(nurse) on 6/28/12 she confirmed that R3's care plan for urinary incontinence lacked interventions. An interview with E10(nurse) on 6/28/12 confirmed that no interventions for the recognized problem and goals had been identified on the alteration in urinary continence care plan. An interview on 06/28/12 with E2, (Director of Nursing) confirmed that no interventions for the known problem and goals had been identified on the alteration in urinary continence care plan. Findings reviewed and acknowledged with E1 (Administrator) on 6/28/12	F 279	F312 August 15, 2012 1. Resident R3 is cognitively intact and able to use call bell for assistance and does receive necessary incontinent care as care planned, and receives assistance with personal hygiene as needed. 2. Current assignments' sheets will be reviewed by each oncoming nurse supervisor to assure assignments are complete and communicated to the staff providing resident care. 3. Rn supervisors will be informed on each of their next scheduled shifts to review each assignment. 4. This will be the responsibility of the nursing team, DON/ADON, and nurse manager. The DON/designee will report to the QA committee monthly. The QA committee will analyze the data for further recommendations.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documents, it was determined that for one (R3) out of (5) residents sampled the facility failed to provide the necessary services to maintain good personal hygiene. Findings include: Review of R3's clinical record revealed she had diagnosis that included Hypertension, Depression, Hypothyroidism, Coronary Artery Disease and was legally blind.	F 312		

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F 312	Continued From page 5 According to the Minimum Data Set (MDS) assessment, dated 1/31/12, R3 was cognitively intact and required extensive assist of two staff for bed mobility, toilet use, personal hygiene and was always incontinent of bowel and bladder. Review of a facility "Resident Concern Report" dated 2/7/12 revealed that on the 11PM to 7 AM shift on 2/6/12, R3 had not received incontinence care. A written statement completed by E7 CNA (Certified Nurses Assistant), dated 2/6/12 stated that she had not been assigned to R3 on that shift and that she had not provided care for this resident for over 3 weeks. During an interview with E2 (Director of Nursing), on 6/27/12 she stated that, R3 did not want E7 providing care for her because her roommate at one time had received care before she did, and that E7 had been reassigned due to R3's request. Due to poor communication, E6 (nurse) was not aware of the situation and did not make the second CNA aware that she would need to provide care for R3. As a result, the facility failed to provide incontinence care for R3, during the 11 PM -7 AM on 2/6/12. The witness investigation statement completed by E8 (CNA), dated 2/6/12 stated that E8 found R3's brief "very wet" when she went in to perform care on the morning of 2/6/12 and that R3 reported to her that she had not been "changed at all on the 11-7 shift". Review of the CNA flow sheet in the Care Tracker computer system lacked evidence that incontinence care had been provided on the 11 PM to 7 AM shift on 2/6/12. During an interview with E2 on 06/27/12 she	F 312		

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F 312	Continued From page 6 confirmed that R3 did not receive care on the 11PM-&AM shift on 2/06/12. E2 confirmed that there was confusion between staff members about who was to care for R3 during the shift. Findings were reviewed and acknowledged with E1 (Administrator) and E2 (Director of Nursing) on 6/28/12.	F 312	F323 August 15, 2012 1. All linen carts are free from items and/or products not appropriate to be stored on the carts. Treatment carts are locked when unsupervised. 2. Random linen carts and treatment carts audits will be completed on each shifts before July 31, 2012 to ensure center continues to provide a safe environment. 3. An in-service will be performed on or before July 31st to educate the staff about safe environment to include proper items on linen cart and locking treatment carts when not in use. 4. This will be the responsibility of the staff educator, who will report to QA monthly any findings that are not consistent with providing a safe environment.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based upon observation, record review and interview it was determined that the facility failed to provide an environment that was free from accident hazards as was possible. Findings include: 1. Observation on 6/27/12 at 9:40 AM revealed a treatment cart on the 600 hall that was left unlocked and unattended in the hallway outside room 611. An interview on 6/27/12 with E9 (nurse) and E3 (nurse) at 9:44 AM confirmed that E9 and E3 were both in room 661 with the door closed, and that the treatment cart should be locked when not in view of the nurse. 2. Observation on 6/27/12 at 9:50 AM of the	F 323		

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F 323	Continued From page 7 clean linen cart in the hallway outside resident room 404 revealed a pink wash basin that was on the bottom shelf of the cart which contained the following items: a.Two packets of Alcavis Bleach Wipe 8x10 towelettes. The package contained the following Precautionary Statements: Hazards to humans and domestic animals. Caution: Harmful if absorbed through skin. Liquid may cause moderate eye irritation. Avoid contact with skin, eyes, or clothing. Wear gloves for sensitive skin or prolonged use since it may cause skin irritation. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco or using the toilet. b.One clear spray bottle that contained a clear liquid that lacked a manufacturer's label. Bottle was marked with black ink, "air freshener". c.Solosite Wound Gel (1) 3 ounce tube , personal cleanser (2) 8 ounce bottles, Moisturizing Lotion, (2) 8 ounce bottles, Shaving cream (1) 1.5 ounce container and Softee Protein Styling Gel (1) 8 ounce jar. All of these products were marked for external use only. Interview on 6/27/12 with E4 CNA (Certified Nursing Assistant) stated that the spray bottle that contained the clear liquid marked "air freshener" belonged to her and that she brought it from home. E4 also stated that "we are not suppose to put things on the cart and that the bleach wipes came from the housekeeping cart". Interview on 6/27/12 with E5 (housekeeping) confirmed that the bleach wipes are supposed to be kept on the housekeeping cart. These findings were discussed with E1 (Administrator) and E2 (Director of Nursing).	F 323		

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Arbors at New Castle

DATE SURVEY COMPLETED: June 28, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint survey was conducted at this facility from June 27, 2012 through June 28, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the survey was 117. The survey sample included 5 residents.	
3201	**Regulations for Skilled and Intermediate Facilities**	
3201.1.0	**Scope**	
3201.1.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date	

Provider's Signature Kathleen H. Ducca Title Administrator Date July 17, 2012

NAME OF FACILITY: Arbors at New Castle **DATE SURVEY COMPLETED: June 28, 2012**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	completed 6/28/12, F225, F279, F312 and F323. **16 Del. C., 1162 Nursing Staffing:** (c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. Nursing staff must be distributed in order to meet the following minimum weekly shift ratios: RN/LPN CNA* Day 1 nurse per 15 res. 1 aide per 8 res. Evening 1:23 1:10 Night 1:40 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. **The law was not met as evidenced by:** Three weeks of facility staffing, covering the period of 27 May 2012 through 16 June 2012 inclusive, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered on the DLTCRP Staffing	Cross Reference to CMS 2567-L survey report date completed June 28, 2012, F225, F279, F312, F323, with a Plan of Correction Date of August 15, 2012. 1. The center maintains current legal requirements for staffing. 2. Weekend RN supervisor has been informed and understands how to project and calculate the staffing PPD 3. RN supervisor will continue to staff according to Eagles law and will contact the DON for direction on staffing when necessary. 4. Staffing PPD is calculated daily and submitted to DON and/or NHA for review.

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STATE SURVEY REPORT

NAME OF FACILITY: Arbors at New Castle

DATE SURVEY COMPLETED: June 28, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Worksheets by Arbors staff, and signed by the Administrator. The **ONE (1)** citation hereon results from that work. Arbors failed to meet the 3.28 daily Care Hours per Resident requirement on the **ONE (1)** day shown below. The Care Hours per Resident attained by the provider on that day are parenthesed. **1.** Sunday, 27 May 2012 (3.22).	